

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011970	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/31/2015
NAME OF PROVIDER OR SUPPLIER VERMILLION PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint #IN00179725.</p> <p>Complaint # IN00179725 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: August 31, 2015</p> <p>Facility Number: 011970 Provider Number: 011970 AIM number: N/A</p> <p>Census Bed Type: Residential: 43 Total: 43</p> <p>Census Payor Type: Medicaid: 26 Other: 17 Total: 43</p> <p>Sample: 3</p> <p>Vermillion Place was found to be in compliance with 410 IAC 16.2-5, in regard to the Investigation of Complaint #IN00179725.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE